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Socio-phenomenology and conversation analysis: interpreting video lifeworld healthcare interactions

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Abstract

Collaborative health and social care begins with human interaction and in particular the healthcare interaction which is expected to be patient centred and has come to mean putting the patient and their experience at the heart of quality improvement. This article focuses on mutual understanding and caring using socio phenomenology. Using a video lifeworld schema to analyse the intersubjective everyday lifeworld of a health consultation rather than a systems (interventions) approach increases not only the public's participation and knowledge of the consultation environment but also the practitioners' awareness of shared intersubjective learning in everyday communication. Health consultation videos provide an opportunity for a wide audience to experience the many kinds of conversations and dynamics that take place in consultations. A visual socio phenomenological approach used in this article provides a method to organise audiovisual emotional, knowledge and action conversations as well as dynamic typical consultation situations. These interactions are experienced through the video materials themselves unlike conversation analysis where video materials are first transcribed and then analysed. Both approaches have the potential to support intersubjective learning but this article argues that a video lifeworld schema is more accessible to health professionals and the general public. This method of analysis focuses on the everyday lifeworld informing face to face person centred healthcare and supports communicative action that underpins a strategic and systematic approach to consultation practice.

A phenomenological approach to caring.

The purpose of this article is to describe how using a video lifeworld schema of social action provides a collaborative forum for increasing understanding of human interaction in the health consultation (Bickerton et al, 2010a).

During the health consultation, personal health experiences are viewed from a perspective of a factual world held in common through the generalised approach to the consultation. In the generalised approach the practitioner organizes the consultation process using strategies such as listening to the health consumer's history, then completing a physical assessment that lead to an assessment and a possible diagnosis and plan of action. The patient is expected to have less understanding of organised strategies for communicating their illness and disease process but may be expected to bring a list of questions about their health and health treatment to their practitioners to begin to be able to support informed decision making. Despite this generalised approach, each health consultation is unique as each patient brings a unique history to the consultation as does the practitioner in their experience. Commonsense reasoning accepts that everyone experiences a world of his or her own. However, there is no way of knowing all the multiple realities of both the patient and practitioner. This article intends to elucidate how a lifeworld schema can support and strengthen these multiple realities underpinning the generalised strategic approach to practice with social action.

This article describes the philosophical development of human interaction through social action and is based on a phenomenological methodology of understanding (i.e. Husserl and Schutz) (Speigelberg, 1972). It argues for a socio phenomenological model of practice which begins from an everyday perspective through intersubjective interaction and involves all videoed participants collaboratively in a dynamic process which organises along a continuum into typical consultation situations (Schutz, 1964). The method of analysis is carried out through experiencing health consultation interaction. The article applies essential qualities of phenomenological sociology and argues that intersubjectivity facilitates collaboration more than positivism or a mechanistic approach (Bickerton et al, 2010b). A phenomenological understanding of consultation interactions, this article argues, supports shared decision making in action more than a method such as conversation analysis (a commonly applied method in health research). It argues that using a video lifeworld schema offers the

opportunity equally for patients as well as practitioners to develop greater awareness of how human interaction affects consultation outcomes. The work of Alfred Schutz, a socio-phenomenologist, emphasized the social and intersubjective nature of our experience of others and identified how the interpretation of human interaction in a culture at a particular time has the potential to affect expectations and in this case those of health and wellbeing. Today a more patient led culture of communication means that a shared understanding of interaction between practitioner and patient could influence healthcare outcomes for individuals in the health service. The relationship between practitioner and patient is changing with active consumer involvement encouraged in healthcare decisions (Stevenson et al., 2004). The use of a socio phenomenological method to interpret videoed health consultations has the potential to build awareness of how our culture influences our expectations and understanding of the consultation process (Atkinson & Heritage, 1984).

Human interaction in western philosophy

The understanding of human nature and of human interaction in particular in western civilisation has changed over time, transforming and adapting to opposing perspectives of knowledge. In early western philosophy human interaction is understood through the relationship of a higher being. In the renaissance human interaction began to be understood through the separation of mind and body and the relationship with God. Finally, in the twentieth century human interaction was focused on human existence alone.

Human interaction can be studied using strategic (objective) or communicative (subjective) approaches (Habermas, 1967). Where research uses objective approaches it is more likely to be scientifically provable and replicable. BF Skinner developed a theory of behaviourism that analysed all actions in terms of cause and effect that is scientific and replicable. Phenomenology on the other hand attempted to describe the essence or truth of everyday experience from a subjective point of view. The philosophic concept of phenomenology attempted to describe rather than provide objective evidence of the essence or truth of everyday experience even though Edmund Husserl attempted to provide objective evidence of his findings (Spiegelberg, 1972). Phenomenology is concerned with how everyday things appear and are present in our conscious subjective experience. The phenomenological method described experience from a first person point of view. Phenomenology is concerned with the structure of experiences which can be described as perception, thought, memory,

imagination, emotion, desire, bodily awareness, embodied action and social activity such as language. In phenomenology it is essential to experience these intentional relationships directly and transparently without drawing on existing theories and belief. It views the structure of experience as intentionally directed toward objects and is an act/object relationship. This relationship is different from the things they represent: there is a thing in itself and a representation of the thing. This act/object relationship exists in the stream of consciousness and involves temporal and spatial awareness that includes kinaesthetic, intellectual, emotional, empathic and intersubjective awareness. Knowledge is built on personal patterns of experience and where knowledge is not transparent, it is bracketed. Bracketed means that phenomenological knowledge is only built from experience that is perceived or understood in consciousness so other knowledge, such as god that may or may not exist and of which human consciousness, has no existence in experiential reality. A transparent essence or thing in itself is arrived at through phenomenological bracketing or epoché and is understood as the essential structural qualities of the phenomenological experience.

Sartre used Husserl's phenomenological approach to develop a psychological theory of the imagination. Sartre's (1969) model of the imagination includes emotion as well as movement and knowledge; whereas Schutz' analysis of consciousness is less concerned with human emotions. Sartre described how knowledge, emotion and movement interactions construct the imagination (Sartre, 1969). Video materials provide a way for everyday conversations to be experienced through the interactions of these act/object relationship which are only separable for the purpose of analysis (Bickerton, 1992).

Husserl unlike Scheler and Schutz (Schutz, 1964, Scheler et al., 1979) did not believe that phenomenology was applicable to the social sciences. Scheler and Schutz understood social action originating in the intersubjective consciousness through the social action and knowledge of the everyday lifeworld. Husserl was never able to realise transparency or interconnectedness in social action and was unable to resolve the problem of human solipsism which for Husserl meant that there was no intersubjectivity or knowledge of other human beings in consciousness only our perceptions of humans as separate present beings. Unlike Schutz, Husserl bracketed social action so that it stood outside the boundary and horizon of the essence of human experience. The possibility of understanding social action in

consciousness as intersubjectivity is the foundation of shared communication in this article that takes place in the stream of consciousness.

Social construction of reality

The socio phenomenological lifeworld recognises consciousness as an unbroken stream of lived experiences where facial expressions and gestures are the “field of expression” for the inner life (Schutz, 1967). Schutz analyses in considerable detail the manner in which human knowledge is ordered in society.

“The fact that the everyday life-world is not a private, but rather an intersubjective and thereby a social reality, has a series of extremely important consequences for the constitution and structure of the subjective stock of knowledge. Because an individual is born into a historical social world, his biographical situation is, from the beginning, socially delimited and determined by social givens that find specific expressions” (Schutz et al., 1973, 243).

Social action, although it is relative to a particular socio-historical situation, provides individual experience with its order of meaning and is relative to a particular natural way of looking at the world (Berger et al., 1979). Schutz (1964) argued that language is built on a stock of knowledge that is acquired to enable social interaction and is built up of social interactions through which the world is understood and is typical of how individuals understand others and their world. Shared understandings are arrived at through social interaction but depend upon the social distance between the participants involved. This distance is dependent on our knowledge of particular people and our lifeworld. So for the practitioner the world of the consultation is likely to be richer and fuller in the understandings of the patient situation from a health perspective whereas the patient’s understanding of the illness process will be richer and the health perspective more distant. Where the lifeworld typical situations are not well understood then the typification is more likely to be narrower, more invariant, and more inflexible. Our understanding of a healthcare interaction is dependent on many factors including personal experience, even though there is common knowledge about healthcare in general (Berger et al., 1979). Individual healthcare differs from patient to patient, practitioner-to-practitioner, NHS service to NHS service and country-to-country, although there is a general overall understanding of illness, disease health and

wellbeing. The natural attitude is how a culture as a whole experiences the consultation process in a similar way and as an example a UK citizen is expected to be registered with a General Practice.

A lifeworld model of practice offers the opportunity for patients as well as practitioners to begin to question the UK natural attitude to the NHS. If patients are to lead the NHS they might appreciate experiencing an overview of health consultation interactions and thinking about the opportunities for engagement in these situations. It also offers the practitioner the opportunity to experience different typical consultation situations and answers to questions such as why they might find themselves sometimes needing to be directive in order to achieve patient satisfaction. Studying video examples of different consultation situations encourages all participants to identify human signs such as language and knowledge, emotion and expression, as well as patterned bodily movements. The lifeworld for Scheler and Schutz begins from an everyday perspective and involves ongoing practical interactions in the world. The lifeworld consists of mostly shared or intersubjective socially created interactions together with or constrained by pre-existing social and cultural structures. Out of these everyday social interactions, typical situations emerge gained from practical experience of the world. It is these typical situations that this article examines through the analysis of videoed health consultations. Schutz's theory of social phenomenology of the lifeworld understood human existence to be experienced in relation to a "social location" of thought (Berger et al., 1979).

“...sociology must be carried on in a continuous conversation with both history and philosophy or lose its proper object of inquiry. This object is society as part of a human world, made by men, in an ongoing historical process” (Berger et al., 1979, 189).

Berger and Luckmann developed their social constructionist theories drawing on the theories of Scheler and Schutz. They also developed a dialectical process drawing on the work of Nietzsche and Marx (Stumph, 1982) grounded in sociology and phenomenology (Berger et al., 1979). Humans develop habitual patterns over generations that become institutionalised. Rather than taking this historical theoretical approach to knowledge, which the authors found too distant, Berger and Luckmann's theoretical approach enables us to understand everyday conversations as applied to the health practice environment. Using a phenomenological

sociology method of analysis, rather than a mechanistic or behaviourist approach to the video analysis intends to enhance patient-centred biopsychosocial and shared connection approaches to healthcare.

The healthcare interaction

“Medicine as a helping interaction between persons is not aimed primarily at truth, but at guiding the ill back to health again.” (Svenaeus, 1999, 285)

Parsons, arguably the first medical sociologist developed a theory of the structure of social action and of the sick role. Parson’s theory draws on phenomenology. Parsons (1975), like Scheler and Schutz, was interested in the theory of action, and the concerns of both theorists were broadly similar. However, Parsons focused more on an objective empirical scientific theory of action; whereas Schutz (1967) following Scheler et al (1970) focused more on the philosophical aspects, the nature of human action itself, Social phenomenology, discussed above addressed ontologic concerns emphasizing that human knowledge is always already given in society and provides a ground for all individual experience and meaning. (Scheler et al., 1979). This order, although it is relative to a particular socio-historical situation, appears as a given to the individual experience, providing the latter with its order of meaning (Berger et al., 1979).

Parsons theory is different in that it dislocates his theory of structural functionalism from the socio-historical context and tends towards pragmatism. Parsons defines patients in terms of *actors, interaction, environment, optimization of gratification, and culture*. Parsons identifies these actors as passive in the socialization and social control process (Ritzer et al., 2003). Schutz provides an alternative and less passive role for his actors, where the health consumer identifies mutual freedom in the intersubjective or interpersonal interaction. Much of Schutz’s work focuses on the social lifeworld, on shared or interpersonal consciousness, and the interaction between individuals in face-to-face meetings in the everyday world, similar to those that might take place in a health consultation.

This phenomenologically shared interpersonal approach to the interaction is quite different from Parson’s more scientific objective theory of action, which consists of objects of orientation that are social, physical and cultural, where structural functional processes are

systemized (Parsons, 1937). Both approaches influenced ethnomethodology which broadly includes conversation analysis (Psathas, 1995).

Ethnomethodology is influenced by the phenomenological approach to the lived experience and everyday life and developed through the fusion of the phenomenological theories of social action of both Parsons and Schutz (Parsons, 1949, Schutz et al., 1964).

Ethnomethodology, similarly to social phenomenology, is concerned with the micro social interaction of face-to-face interactions (Meltzer et al., 1975). Both ethnomethodology and phenomenological sociology share a belief that actions and behaviour occur between thoughtful and creative people. Schutz (1967) describes this action as a dialectical relationship between individuals' in the co-construction of reality. Ethnomethodology unlike socio phenomenology focuses less on perceptual knowledge in consciousness and more on identifying and objectifying embodied actions as social facts in lived experience, It extends phenomenological concern to an analysis of how an experience is accomplished. This change in focus moves ethnomethodological analysis away from analysis of the experience to how people make sense of their experience. Ethnomethodology is interested in learning about the rules or orderliness of human expressions that influence social interaction and the practical ways that organise these expressions and give them sense. In this manner, Garfinkel moves beyond Schutz -in the understanding of human behaviour constructed through unique social actions– to a systematic search for ways where shared meanings are taken for granted and sustained in a social structure (Psathas, 1999).

CA can be considered within the broad movement of ethnomethodology because they both study social order focussing on the indexical and reflexive features of practical actions (Psathas, 1995). CA studies how action, structure and intersubjectivity in social action are achieved and managed in talk in interaction. These features are understood as always interpreted through the context in which they are constructed. CA moved away from examining the objective reality of social facts within the context of everyday actions to the consideration of the structural qualities of the use of language in social interaction. These everyday social actions are understood always as interpreted through the context in which they are constructed. CA examines the structural qualities through the indexical and reflexive sequential organization of everyday talk and interaction. CA is concerned with the details of talk in interaction and focuses on discreet elements of talk-in-interaction. It studies

syntactical relations between actions or rather social interaction. CA takes naturally occurring talk and examines for example the beginnings and endings of conversations to discover how language is related to thinking. Using this approach the research starts with an audio transcription: rather than analysing audiovisual materials directly. CA analyses transcripts of naturally occurring talk, from audio or audiovisual tapes that are of interest, to discover where speakers pay attention to the dialogue to produce a structure, organisation or orderliness. CA analyses transcriptions of visual materials but sees visual materials such as gaze and gesture as supplementary to the transcription of spoken interaction rather than an essential part of the process of interpretation (Harper, 1988). In the context of the health consultation CA has been used as a method to build a considerable body of work that provides evidence of action, structure, and intersubjectivity in the consultation talk in interaction that is scientifically provable and replicable.

CA is concerned with the structure of social interaction discreet elements such as turn taking, and the order of interaction and includes an awareness of how our culture influences our expectations and understanding of the consultation process (Sacks, 1989). In order to analyse these syntactical relations CA has developed a system of symbolic notations that describe the details of an interaction through what and how people are speaking. It was Gail Jefferson in the main who developed this system of notation which identifies kinds of intonation, pauses, sound stretches, emphasis etc (Sacks, 1992). Jefferson's notation includes emphasis noted by underlining or italics where sounds stressed, stretched sounds use colons, cut off sounds are marked by a dash, pauses of less than 2/10 seconds by a dot (.), brackets ([]) show overlapped speech, punctuation indicates pitch e.g. (?) rising intonation, (,) comma continuing intonation and (.) falling intonation at end of sentence.

CA is commonly used to systematically explore syntactical arrangements in the health consultation. Using CA Champion and Langdon (2004) identified the introduction of new topics in health consultations by patients. The results of their research supported the importance of the opportunity for multiple topics in a consultation rather than problem oriented consultations. CA is a useful method to use to identify the mechanism of when and how in the course of the conversation interaction new health problems are brought up by a patient during a health consultation (Champion, 2004). Champion below provides a fragment

of one of his CA analyses and this fragment you can see how the Jefferson notation is used (Campion, 2004 p 84-85).

Fragment 0 [A3:c3]

Patient (Pt) a 61-year-old man, accompanied by friend (Fr).

3 Dr: hello: (.) hi: come on in have a seat Mr Worthing=

4 Pt: =hello=

5 Fr: =hello

6 Dr: got moral support with you to:day have you

7* Pt: yeah I've had had to:err first of all (.) I was drunk about a fortnight before Christmas and I fell (.) did all my lips and my teeth,

8 Dr:ri:ght=

9 Pt: ='nd had stitches and I rung here they didn't tell me at the hospital to come and have me: stitches out=

10 Dr: =umm=

11 Pt: =or what so I come up here nd they said you've got to go back to the hospital=

12 Dr: =ri::ght=

13 Pt: =so any way I've rung hospital and they said well we don't know now't about it you've got to do as you are (.) some have come out here but I've still got some underneath here=

14 Dr: = okay

15 Pt: nd I don't know whether they should come out because it's a fortnight ago today

16* Dr:ri:ght we need to have a look at that don't we.

17* Pt: nd I've nd I've got a: form for a claim if you can do that for me(.) it's one of these err HSA claims for any accident

18 Dr: o: h ri:ght=

19 Pt: =so: =

20 Dr: =yeah sure

21 Pt: I haven't filled it I haven't err

22* Dr:yeah we'll have a look at that in a minute shall we=

23* Pt: =right so nd apart from that I've got somethin' on my chest and I feel absolutely (.)crap

24 Dr: ri:ght (.) lets take one thing at a time shall we (.) can I just look at this err

25 ((doctor examination))

Elements of a lifeworld schema of practice

The elements in the lifeworld schema of practice are quite distinct from a CA analysis using Jefferson's notation. Using a socio phenomenological model to describe interactions involves less discrete interpretations than conversation analysis provides because the interactions are interpreted through broader brush stroke like experiences. The lifeworld model does not transcribe the audiovisual materials word for word, gesture for gesture, identifying particular emotions, rather it is concerned with a more generalised interpretation of consultation interaction practice (Bickerton et al, 2010b). There is always a shared (intersubjective) connection already present in the patient and practitioner interaction and this is the foundation for intersubjective interaction which accepts that all encounters begin from a shared origin (Schutz, 1964). In analysing this socio phenomenological experience a conversation can be:

- Engaged with participants attentive to each other

- Objective with a non engaged conversation

The analysis interprets emotion, knowledge and movement conversations that include:

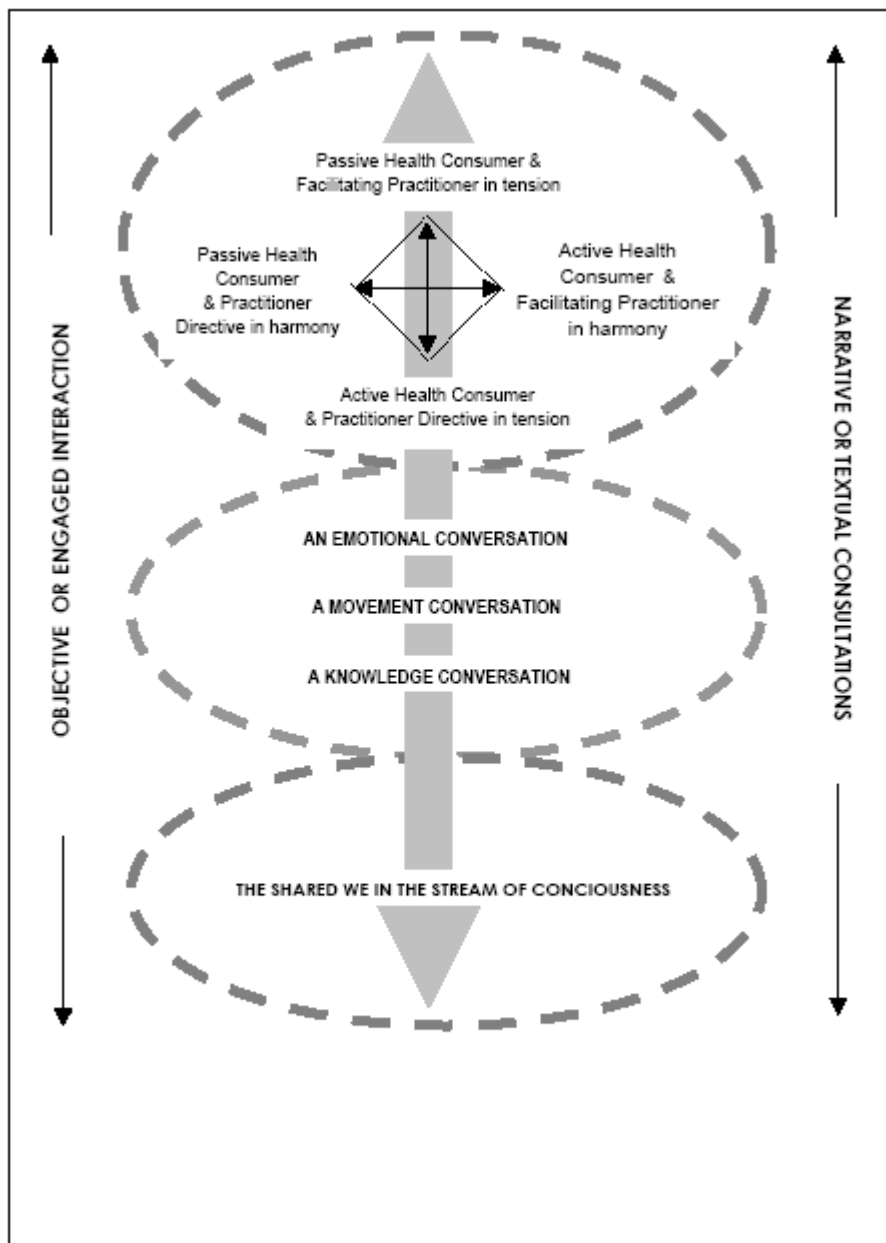
- knowledge interaction focusing most on sharing information,
- movement interaction experienced through non-verbal elements such as gestures,
- emotional interactions experienced through feeling elements (Sartre 1969)

A conversation contains all these elements but in this analysis one of the elements is identified to provide an overarching typology of the conversation and this is decided by the viewer of the video.

Typical situations occur as consultation actions cluster together into dynamic typifications and emerge through an accumulation of conversations falling along a continuum of one of four typical situations that provide the overall sense of the consultation practice dynamic which maybe active/passive, facilitative/directive in tension or harmony (Schutz 1964). Again the viewer of the video decides which is the overarching situation depicted in the video.

Typical textual and narrative situations present a typical situation that can be objective or engaged. Narratives are fully engaged face-to-face interactions that integrate multiple combinations of perception through linearity, resonances, and/or rhythm. They are never objective.

The components of the video lifeworld are organised differently from CA and is a method that this article argues is easier to access and understand than the CA method. A visual schema illustrates an interpersonal shared, alongside and an engaged lifeworld, as well as a lifeworld of typical situations that organize through knowledge, movement and emotion conversations. This dynamic process in tension or harmony has the potential to co-construct texts (that may or may not be engaged) and fully engaged narratives and is illustrated in the lifeworld schema below in Figure 1 (Bickerton et al, 2010a).



The method of analysis using this video lifeworld schema is demonstrated through a consultation described below (Bickerton et al, 2010b, p165-166)

“Case 3—A woman is sharing with a practitioner the fact that she is having difficulty swallowing. She tells the practitioner that her throat hurts to the extent that she is concerned she may soon not be able to swallow. Interestingly she doesn’t look too concerned. The practitioner empathises with the consumer as she relates her health history over the past 3 days. She actively shares her health problem as the practitioner facilitates the conversation. The two participants are engaged sharing knowledge and are interacting in harmony and their consultation dynamic presents an active participant and facilitative practitioner. Following the consumer history the

practitioner performs an objective examination. The subjective part of a consultation is dependent on the quality of the consumer and practitioner communication more than the objective assessment when the practitioner performs an examination of the throat, ears and lymph nodes. After the objective examination, the practitioner shares his assessment as a possible quinsy (peritonsillar abscess) and tells the woman it could be serious and that he is referring her immediately to an Ear Nose and Throat (ENT) specialist. As the practitioner speaks, sharing this information, the participant interaction dynamic changes. The video shows the health consumer listening intensely to the practitioner. Her posture is less upright and she appears to be passively accepting what the practitioner shares as he directs a knowledge conversation. There is an anxiety and movement element to the conversation but the knowledge element holds the attention of the participants. The dynamic presents a passive consumer and a directive practitioner in a typical situation that is still in harmony but is diametrically opposed from earlier interactions.”

To summarise using this lifeworld schema the video is examined for the orienting and synthesising activity of emotions, movement and knowledge consciousnesses that construct conversations in the video. The video lifeworld analytical process enables participants to begin to understand the interaction from the already present shared connection in the stream of consciousness. That is to say, the consultation is always oriented to a shared connection between participants and the participants distance themselves from the shared connection in order to articulate, reflect and objectify their place, thus influencing the process. The consultation is always considered as a whole context with neither participant being more or less important than the consultation as a whole. The whole context in this study includes the lifeworld person centred aspects of the health video, and the audiovisual world of the consultation is where the interpretation begins and ends. The consultation is thus always a gestalt presenting more and not less than the sum of its parts.

Visual Sociology

The life-world schema provides a visual tool for phenomenological sociology that has the potential to integrate four modes of visual sociology: the scientific mode, the use of video for image elicitation, the use of a phenomenological methodology, and a reflexive model of practice (Harper 1988). This article argues that interpreting health consultation interactions through video materials provides an alternative way to understand the orienting and synthesising processes involved in shared consultation practice (Bickerton et al, 2010b).

CA tends to use recorded materials to better understand linguistic elements such as turns in the conversation interaction. However, CA doesn't integrate the visual materials themselves into their analysis and are more likely to use audio recordings to identify syntactical relationships than visual images. CA follows a rigorous scientific method that is replicable and uses image elicitation on occasion. It does not use a phenomenological methodology but does use reflexivity as a mode of practice. CA is also different from socio phenomenology because it doesn't consider the visual materials themselves to be unique to the analysis although all CA is completed through the analysing recorded transcriptions. These recordings are more likely to be audio recordings used to identify syntactical relationships than visual images. The video lifeworld schema, it can be argued provides a better understanding of the orienting and synthesising processes involved in a shared consultation practice and achieves this through the integration of the video materials themselves as act/object relationships (Bickerton et al, 2010b). The video schema developed in this article has not been tested to see if results of analyses are scientifically provable. However, it should be noted that the video lifeworld schema appears to offer a simpler method for the general public as well as professionals to experience and review health consultations and to consider how their participation and involvement in the process can affect outcomes.. This approach is different from CA. For example using CA Heath demonstrates how the relationship between verbal (speech) and non-verbal (body-movement) in doctors' activities can be contextualised within the work environment (Heath, 2002). The video lifeworld schema raises awareness not only of the non verbal and verbal actions of the practitioner but includes the interaction between all participants in the consultation process and illustrates the dynamic of the consultation process as a whole not only that of the practitioner.

Discussion

This article argues for a phenomenological approach to interpret consultation interactions which is different from a more mechanistic and positivistic approach. It offers the opportunity for deeper understanding of the consultation process which is inclusive of everyday conversations and narratives. What the socio-phenomenological approach provides over a phenomenological approach is that the analysis of the lifeworld interactions incorporates an intersubjective perspective and provides the opportunity to begin examining interactions as they are nascent from a shared origin. This article argues that considering the shared

dynamic throughout a consultation interaction helps understanding of the effects of participant approaches on each other. Co-operation and collaboration are then the focus of understanding health interactions rather than the differences in professional as well as patient or service user approaches. The lifeworld schema emphasises a shared focus and is more able to identify compromises that all participants may make in a consultation depending on the consultation conversation and dynamic. This approach can be contrasted with CA analysis which also developed out of phenomenology and is part of ethnomethodology (Psathas, 1999) which has evolved to focus on the effects of discrete elements of conversation. With CA the audio and visual materials are transcribed, written down and then interpreted. CA focuses on analysing transcription details of the sequential or syntactical structures of formal talk. CA is not so concerned with the semantics and pragmatic elements of talk and in this way. CA is very different from the socio phenomenological lifeworld described above. The socio-phenomenological lifeworld analytic framework described in this article is more concerned with the semantics and pragmatic effects of emotions, movement and knowledge on the conversation and how a typical dynamic emerges in a consultation. This lifeworld approach interprets interactions and ongoing dynamics between participants rather than the discrete structural and syntactic interactions of CA.

CA is commonly used to interpret health practice and, in particular, general practitioners practice (Campion et al., 2002). Champion et al used CA to analyse GP students training to become a member of Royal College of General Practitioners (MRCGP). Champion et al examined how the GP student identified the reason for the patient's attendance, explored and tackled the problem as well as explaining the problem to the patient and making effective use of the consultation and found that the doctors demonstrated only a limited ability to achieve patient-centred outcomes (Campion et al., 2002):

“The ability to elicit patients’ ideas, concerns, and expectations is fundamental to good consulting, but our results suggest that few doctors regularly use this ability, even in a highly selective set of consultations. Likewise the checking of understanding and the involving of patients in decision making both likely to improve concordance are rarely demonstrated” (Campion et al., 2002, p 692).

CA provides a model that demonstrates discrete measurements of conversation dynamics and how these measurements affect patient centred care but it does not focus on the audiovisual

elements of these dynamics in action unlike the lifeworld model. CA and socio phenomenology can be considered to be complementary because CA provides discreet structural analyses of participants' everyday conversation whereas the socio phenomenological video lifeworld as described in this article focuses on how these discreet elements are integrated through lived experience in a video consultation itself.

Schutz emphasized the social and intersubjective nature of our experience of others and also focused on how shared meanings, social contexts, and social interaction colour the construction of this intersubjective experience. The intersubjective everyday experience for Schutz depends upon language and the stock of knowledge in a culture. Social interaction is dependent on how the participants typify others and their world using this stock of knowledge. And most importantly shared understandings in health consultations are dependent on the social distance between participants. Using video consultations has the potential to bring practitioner and patient to a closer understanding of the health problem at hand, with better access to the unique and rich quality of the particular consultation. Evidence suggests that the consultation at the heart of healthcare still continues to be medically driven or directed (Bensing et al., 2006) and different practitioners have different approaches to communication in consultation practice (Collins, 2005). Where the video viewers are encouraged to view the consultation using the lifeworld schema there is the potential for better understanding of collaboration through the identification of typical interactions and understanding of how these typical dynamics can affect health outcomes. This lifeworld approach offers the possibility of understanding the consultation culture and the opportunities provided by particular individual interactions in the consultation to change practice.

Summary

This video lifeworld schema approach supports collaboration between patients and practitioners. This shared video lifeworld offers patients the possibility to view how an active role in their health care consultation and a more knowledgeable awareness of their effect on the consultation has the potential to affect health outcomes.

A socio-phenomenological analysis of videos and health consultation videos in particular provides an opportunity to understand better intersubjective, shared understandings and collaboration. The videos provide an opportunity to experience different kinds of

conversations as well as the discovery of typical situations that take place in the health consultation. This approach applies equally to both health professionals and the general public who could benefit in reviewing video consultations in order to understand the benefit of potential interventions for different types of human interaction.

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